

PROCEEDINGS OF THE SPECIAL STUDY INSTITUTE

P. H. ...



IMPROVED SPECIAL EDUCATION SERVICES FOR VISUALLY IMPAIRED CHILDREN WITH MULTIPLE HANDICAPS

CALIFORNIA STATE DEPARTMENT OF EDUCATION
DIVISION OF SPECIAL SCHOOLS AND SERVICES

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Proceedings of the
Special Study Institute

IMPROVED SPECIAL EDUCATION SERVICES
FOR VISUALLY IMPAIRED CHILDREN WITH MULTIPLE HANDICAPS

November 6-8, 1968

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Edited by
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San Francisco, California

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INTRODUCTION

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The State of California offers many opportunities for cooperative efforts between those who administer programs for handicapped children in the schools and those who offer professional preparation for teachers who serve the children directly. There are many examples of projects in which the teacher education institutions and the State Department of Education have participated in activities designed to improve services in local school districts. Such efforts have included sharing of lecturers, consultant services, committee activities dealing with curriculum improvement and credential reforms, as well as social action and legislative programs. The most recent projects, however, have been aided largely through government funds made available as a result of state and federal planning. These have far reaching effects, both for those who function in the projects and for those who may share in the benefits from the final written reports.

This report results from a three day Institute sponsored cooperatively by the State Department of Education,

Bureau for Physically Exceptional Children, and the Department of Special Education of San Francisco State College. The project was administered through the Frederic Burk Foundation for Education, and specific responsibility for program development and the final report was assigned to two faculty members of San Francisco State College, Miss Georgie Lee Abel, Professor of Education, and Mr. Philip H. Hatlen, Associate Professor of Education, Department of Special Education. Three representatives from the Bureau of Physically Exceptional Children accepted responsibility for securing the original grant and providing continued support and active participation in the planning. They were Miss Dorothy Misbach, Miss Joan Sweeney, and Mr. Gene Black. The planning sessions between the two organizations added to the success of the project as well as the administrative considerations. The grant was submitted and approved by the State Department of Education, Bureau for Physically Exceptional Children, and funds were made available by the United States Office of Education under provisions of Public Law 85-926.

The purpose of the Institute can be best stated in its title, "Improved Special Education for Visually Impaired Children with Multiple Handicaps". The motivation came largely through the increasing number of children in the state who are identified as severely impaired children.

The need for more and varied services, as well as professional persons to serve in these programs, was emphasized and justified through two recent studies conducted in the state by Dr. Berthold Lowenfeld¹ and Dr. Donald Calvert.² The greatest motivation, however, came from the teachers themselves, who found severely handicapped children in their schools, and asked their administrators for more professional help to meet new and complicated problems. Indeed, they requested "Improved Special Education Services for Visually Impaired Children with Multiple Handicaps".

Those responsible for compilation of these Proceedings wish to express their sincere appreciation to:

(1) The General Session speakers for their excellent presentations, their consultant service to the group sessions and their written papers.

(2) The Administrators of School Districts who provided financial assistance to supplement funds available through stipends in order that their direct service persons and key administrators might participate in this Institute.

(3) The Frederic Burk Foundation and those in finance

¹Lowenfeld, B., Report on multihandicapped blind and deaf-blind children in California. A report to the California Department of Education, May, 1968.

²Calvert, D. R., A report on multihandicapped deaf children in California. A report to the California Department of Education, May, 1968.

and regulations in the State Department of Education for their assistance in drawing up the contract and clarifying legislative and financial information.

(4) The Department of Special Education, San Francisco State College, for its total support of the project, and to the following key faculty members for their assistance in reading this manuscript, participation on the program, and various types of consultant services: Mrs. Marjorie Greeley, Assistant Professor of Special Education; Mr. Richard Holm, Assistant Professor of Special Education; Miss Eileen Jackson, Associate Professor of Special Education; Dr. Joseph Lerner, Chairman of Department of Special Education; Dr. Priscilla Muir, Professor of Special Education; and Dr. Francis Warner, Associate Professor of Special Education.

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(6) Graduate students in the Department of Special Education at San Francisco State College at both Masters and Doctoral level for their assistance in many activities related to the Institute.

(7) Miss Dorothy Misbach, Miss Joan Sweeney, Mr. Gene Black of the California State Department of Education,

for their most valuable guidance, consultant service, and participation in all stages of this program.

(8) The typists who gave valuable assistance in the preparation of the Institute and the Proceedings: Beverly Campbell, Colette Salaun, and Helen Young.

We submit this report in the hope that it will be of value to all those in the state for whom the original project was planned.

PSYCHO-EDUCATIONAL DIAGNOSIS
A DERIVATIVE OF CLASSROOM BEHAVIOR

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The topic I have chosen today was perhaps chosen in haste. Had I realized how difficult it was going to be to document some of the things I am going to say, I probably would have chosen almost anything else to talk about.

My purpose today is to say something -- anything -- that you will remember when you are back in your classrooms. I am sure that you are well aware of how difficult it is for a speaker to leave even one meaningful thought with the members of a group such as this. My only measure of meaningfulness is: Will anything in your classroom be changed as the result of anything you have heard here today?

In order to say something that you will remember next week, or the week after, or next year, I have decided to start right back in your classroom with children like you face every day, and with teachers like yourselves. To this potion, kids and teachers, I will add one more item -- differential diagnosis, based on massive amounts of data derived from psychological, neurological, and other medical

tests and recommendations. Then, I want to examine with you the amount of new information about the child which is added to your knowledge of him after the parents have been referred to the psychologist, the school worker, the neurologist, and the EEG technician -- not to mention the pediatrician, the otologist, the ophthalmologist, the language therapist, and the psychiatrist.

In simplest terms, I would like to suggest to you that a good classroom teacher probably possesses more important data relevant to the special educational needs of each child in her class than any other person who comes into relatively brief contact with him. Each of the specialists involved can hope at best to obtain a relatively limited sample of the child's behavior. The psychologist may spend an hour, two hours, perhaps even two visits of two hours each. The psychiatrist probably spends 30 to 40 minutes. The neurologist may spend an hour at most. The EEG may take an hour. The pediatrician may have known the child since birth, but he probably sees him once a year, and then is largely concerned with immunization shots, strep throats, tummy aches, etc., or he may even be concerned with extremely serious physical problems of a long term nature as in the case of children born with multiple physical anomalies (webbed feet or hands, malformed ears, etc.) or requiring medication which is difficult to regulate.

No matter how well these specialists may know their very specialized aspects of the child's problem, they are not intimately concerned or knowledgeable about his educational needs, 5 hours a day, 180 days or more a year, as you are.

The deplorable part of this situation is that most classroom teachers are completely unaware of their latent abilities to diagnose the educational needs of the children in their classrooms. They do not realize that their careful description of the child's behavior, and their careful analysis of the causative factors involved in classroom behavior, can be more meaningful in terms of educational planning than the most carefully executed work of any of the specialists involved.

The primary reason that enables any of these specialists to tell the classroom teacher anything that she does not already know about a child in her class is that the specialist is child-oriented, whereas too many classroom teachers are method-oriented. As I hope you will gather from some of the cases we will discuss, some teachers need to spend more time following the cues given freely by their students, and less time vainly trying to fit a child into a mold unsuited to his learning processes.

A second reason that prevents teachers from using their available information about a child's methods of learning -- and instead seeking help from those who know less

about him -- involves the teacher's perception of herself. Most often she does not perceive herself as a diagnostician -- hence she does not diagnose. Or, she does not have the fancy labels to attach to the behavior, so she does not value her judgment as highly as that of the specialist who may sound better, but know less, about the child and the classroom.

Before we look at some cases that have brought me to this point in my thinking, let us examine a few basic assumptions. The first is that every teacher here who is teaching a classroom of normal children has two or three children sitting in her classroom who would be diagnosed as having learning patterns so deviant as to require very specialized teaching methods if they are to maximize the potential they were born with. If you are a teacher of the retarded, you probably have a much higher than normal percentage of these children with severe learning disabilities in your classroom. By very expert guessmanship, the percentage of normal children with severe learning disabilities may run from 5 percent to 20 percent, depending on the group upon which this expert judgment was based. Marianne Frostig, for example, estimates that 20 percent of kindergarten children have serious disabilities in visual perception. Kephart estimates between 15 percent and 20 percent. Dr. Kirk has estimated the incidence

at 3 percent of the total school population. The only incidence study that has been done, that of Norris Haring in the Kansas City, Kansas, public schools, has reportedly found 8 percent of kindergarten children in need of special education facilities because of severe learning disabilities.

The second basic assumption is that no teacher here has adequate ancillary personnel -- neurologists, psychologists, social workers, speech pathologists, etc. -- available to do a good diagnosis. With rare exceptions, your only chance for specific diagnostic help lies in referral to outside agencies, child guidance centers, universities, mental health clinics, or perhaps a visit from your reading consultant or supervisor from your diocesan office. Each of these possibilities will probably result in little specific help for you this year.

If we can accept these basic assumptions as true, the solution is readily apparent. The syllogism, when pared down to basics, would sound something like this:

- Children with severe learning disabilities are presenting a challenge to every teacher in every school;
- Adequate diagnostic help is not available to most teachers;
- Therefore, teachers must learn to rely on their own latent diagnostic abilities.

The third basic assumption is that the model upon which the Illinois Test of Psycholinguistic Ability was designed is useful even when profiles of specific children are not

available. I am assuming that most of you will not learn to administer the ITPA and will not have test results available. I am also assuming that you can learn, with only a small amount of difficulty, to fit the behavior which you observe in the classroom, into appropriate spots in the model and construct your own profile, or do your own psycho-educational diagnoses, based on everything you know about a child and not on a few samples of behavior as we psychologists do.

Let me describe a few cases which have been referred to our Psycho-Educational Diagnostic Center, and point out the precision with which many of these children had been diagnosed by their teachers, although most of the teachers had no idea of how close they were.

Penny: C.A. 9-5
M.A. 8-3
I.Q. 88

Gr. Pl. 4.1

Teacher's Comments	Test Data
1. Poor coordination	1. Motor Encoding 5-10
2. Poor retention. Can't differentiate between <u>more</u> and <u>less</u> .	2. Auditory-Vocal Sequencing 4-10
3. Has a problem following directions. She nods her head as if understanding, yet when left to work independently has little idea of what	3. Auditory Decoding 7-11 a. Motor Encoding 5-10 b. Visual Decoding 5-10

Teacher's Comments

Test Data

she is going (3a,b). On one occasion she was to print three sentences telling her name, address, and phone number. All street names and unknown words were printed on the board. Her paper looked like the scribblings of a pre-schooler. Her first name had been poorly printed on the first set of lines and the rest of the paper was filled up with poorly printed "made-up" words.

4. She makes up a good story to coincide with the picture.
5. Her story coincides with the book story although the words are not necessarily the same as those on the printed page. When confronted by any unknown word, she will call it anything in order to get past it.

4. Vocal Encoding 9-0
5. Visual Motor Association 6-10
- Durrell Oral Reading 2.2
- Silent Reading 1.2
- Listening Comprehension 3.5

Previous rotations on Binder have disappeared.

Gary: C.A. 7-7
 M.A. 6-6
 Verbal I.Q. 94
 Performance I.Q. 82

Gr. Pl. 2.4

Teacher's Comments	Test Data
<p>1. We do not know what Gary's actual capacity is. On the Perceptual Motor Ability Test in 1/64, he tested 72. The work he produced, occasionally, is not that of a child with a 72 I.Q., but a child with a normal I.Q.</p> <p>2. Does not understand what he reads, although he can read at 1st grade level. He is a sight reader and although he knows his beginning sounds, he is unable to apply them while attacking a word.</p> <p>3. He does not follow directions. Does not comprehend directions, and becomes easily confused when directions are given to the group. His speech is also poor. He is receiving speech correction. He does not listen.</p> <p>4. His muscle coordination is very poor. He cannot skip or hop correctly. Occasionally Gary has fallen out of his seat or knocked his desk over.</p>	<p>1. WISC:</p> <p>Verbal I.Q. 94 Performance I.Q. 82 Full Scale I.Q. 87</p> <p>2. WISC Similarities Subtest low Visual Decoding 4-9 Visual Sequencing 6-4</p> <p>3. Auditory Vocal Association 4-5 Auditory Vocal Sequencing 5-1</p> <p>4. Kephart Perceptual Rating Scale Very low Immature</p>

Teacher's Comments	Test Data
5. He is quite shy and just recently has been communicating more freely.	5. Vocal Encoding 4-5
6. He will not work alone. He cannot sit still. He will not do seat work without supervision. He constantly talks out in class. His handwriting is illegible. Goes through many antics when reprimanded: makes loud noises, lies on his desk, acts silly.	6. Neurological Exam: In view of the hyperactivity, poor attention span, combined with a marked inversion of letters and words and poorly developed stereognosis, this may mean no more than immaturity of the function of the central nervous system. However, a nidus of an organic brain deficit due to slight brain damage at birth cannot be excluded at this time. He may be a candidate for tranquilizers, perhaps combined with a stimulant such as Ritalin. I have recommended that an EEG be obtained. After this has been done, I will make my final recommendations for neurological management.
	EEG Impression: Mild 14 and 6 per second positive spike activity and one burst of petit mal seizure activity.

I could show you a great many more specific cases like this, for they happen with such frequency that I am convinced teachers can do a good job of diagnosing, if they

have a conceptual framework that helps to make some sense out of their daily observations of how children learn.

In summary:

1. You all have children in your classroom who need careful diagnosis of their learning disabilities. You probably are the only ones around to do it.
2. Sharpen up your powers of observation.
3. Increase your confidence in your ability to fit your observations into the theoretical model.
4. Check your observations against those of other teachers on the charts which you are welcome to use.
5. Modify what you do in your classrooms according to the recommendations which have been made for children whose teachers made similar astute observations.
6. Check with the Holy Ghost once in a while so that you will be right at least as often as the other experts who are far more confident than you will be.

PREScriptive TEACHING: A PROCESS FOR REMEDIATION OF SPECIFIC PROBLEMS IN ACADEMIC LEARNING

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University of Southern California

This previously written unpublished paper was submitted by Dr. Peter in the hope that it might be more suitable for the written report than the type of material presented at the Institute. At that time he showed a film and discussed his work with the child shown in the film.

Definition

The word "prescribe" means literally to "write beforehand" or to "set down the direction". If teaching is based upon sound learning principles, then these principles prescribe teaching. In this context teaching includes those school functions which facilitate learning, the most important of which is instruction in the classroom. It deals primarily with the means for achievement of sound educational goals for educationally handicapped children.

Origin

The rationale and methodology described in Prescriptive Teaching¹ developed as a result of experiences in working with handicapped children.

A methodology emerged which assists educators and

¹Peter, Laurence J., Prescriptive Teaching, New York, McGraw-Hill, 1965.

consultants in solving the dilemma of assimilating and applying information pertaining to the exceptional child. It provides them with a systematic approach to link medical, psychological, and social diagnoses, thus helping them to translate the different diagnoses into reasonable therapeutic terms applicable to the calssroom.

A child can be referred by the school to a variety of diagnostic and treatment clinics, and social agencies. Frequently, the diagnosis received from these resources is difficult to implement in the classroom. This situation results in considerable frustration on the part of the diagnosticians when they see their diagnosis apparently being ignored. The teacher is frustrated because the help expected from the diagnosticians was not forthcoming.

Prescriptive Teaching provided a solution by establishing what is educationally relevant in terms of the handicapping consequences to the child's learning. It then translates this to the teacher and others responsible for action. The specific elements of the educational program are thus related to the diagnosis. Prescriptive Teaching assembles diagnostic information in a manner that facilitates appropriate teaching, making a significant contribution to improvement of the education of disturbed or disabled children.

Recently educators and the public have exhibited a keen interest in learning disabilities in children. This interest has been aroused mainly by a new emphasis on perceptual problems in children generally and on compensatory education for culturally deprived children. Prescriptive Teaching results in more careful educational diagnosis and specific treatment for these educational problems.

Psychologists have traditionally pursued the study of verbal learning by means of experiments with nonsense syllables and other materials carefully divested of useful information. The problem the educator must face is how to determine what is relevant to the classroom. Added to this is the complex information which results from the interdisciplinary team approach to diagnosis.

Through Prescriptive Teaching a model for integrating and translating diagnostic findings into teaching is provided. This model utilizes diagnostic information from many sources and employs the information in the utilization of a wide variety of educational techniques in the solution of the child's difficulty. This is particularly important in teaching moderately disturbed, learning disabled, or multiple handicapped children where a number of educational variables must be modified. The model in no way limits the availability of techniques,

but rather facilitates the use of appropriate educational modifications.

Educational Responsibility

The most remarkable feat of learning any human performs -- learning to speak his native tongue -- is accomplished, in the main, without formal instruction. The vast majority of children, in a normal environment, will develop the competencies needed to survive in that environment. Some children have learned to read and write with little or no formal instruction, and many have learned from parents or from other children who have had no professional teacher training. Much of the child's learning is incidental. The stimulus events in the environment elicit a constantly expanding repertoire of responses as the child's capacity for responses increases through growth. This maturation process results in a continually new production of interactions with the environment. These interactions are strengthened or weakened by environmental consequences. This natural or informal process, the child's developing capacities for response, the eliciting events in the environment, the child's resultant increase in behavioral responses, and the shaping of these behaviors by their consequence, results in appropriate incidental learning.

Because of the nature of the growing organism and the major role of incidental learning in the total education of the child, educators have been allowed to deal in generalities about the processes of education. Because most children will learn quite well by almost any method, or in spite of any method, general educators have been spared the necessity of studying the process of instruction in a scientific or systematic way. This has permitted us to be vague, and to deal in general terms about understanding the child.

Limitations of Present Knowledge

The classroom has not as yet been subjected to the kind of research which determines all the components of good teaching. Scientific investigations of teaching have been faced with the dual problem of the complexity of teaching and inability to control factors outside of the classroom. Statistical methods have attempted to control these variables by sheer numbers. Laboratory methods have traditionally isolated or abstracted simple elements from crude experience and pursued the study of learning of nonsense syllables and other material carefully divested of useful information. Scientific investigations have had to face the problem of the complicated and untidy nature of classroom experience. Both laboratory and statistical methods

of studying the teaching-learning situation deal in abstraction of simplification and are therefore in danger of missing significant factors.

This danger of course exists in all scientific efforts. A classic illustration is Liebig's discovery of the functions of carbohydrates, fats, and proteins in his study of nutrition. In isolating these elements from the untidy complexity of our common everyday food, he did not realize that he had ignored very significant elements. In consequence, dieticians for many years concluded that fresh fruit and vegetables were only a luxury and that salads were merely a garnish adding a pleasant but unnecessary frill to our eating habits. Important as Liebig's discovery was, it did not focus attention on the totality or complexity of an adequate diet.

Our present knowledge of teaching is somewhat parallel. Some elements which apparently contribute to effective teaching have been isolated and studied, but when attempts have been made to teach by these elements singly, the results have generally been disappointing. Prescriptive Teaching attempts to incorporate some of these known elements but does not presume to prescribe the totality of how to teach.

Education is concerned with that part of adaptive behavior which comes under the influence of teaching. Pre-

scriptive Teaching helps us base our curriculum on what we know about child development. The child's psychological development is made up of progressive changes in the different ways of interacting with the environment. It is the teacher's responsibility to arrange stimulus events which will elicit these changes and reinforcing events which strengthen these changes. These stimulus events and reinforcing events are the specifics of our technology.

The school's influence on the child's learning is limited to the events before behavior occurs and to events after. In psychological terms these are referred to as stimulus events and reinforcement events. If these events are arranged so as to elicit progressive change in the motor, perceptual, social, and cognitive development, and to allow reinforcing events to become attached to these changes, learning is at an optimum.

Toward a Science of Teaching

Traditionally many teachers have intuitively selected the appropriate modification for children with specific learning problems. Valuable though intuition is, we must also develop a science of teaching. A profession cannot be developed adequately on a basis of methodology which cannot be systematically studied and communicated.

The elements of Prescriptive Teaching are not new. It

is a rationale and methodology for establishing a more effective integration and implementation of well-established and scientifically tested techniques. The outcomes of implementation of Prescriptive Teaching can be described in three ways: individual results, program improvement, and professional development.

(1) Individual Results

Follow-up studies indicated significant improvement for the child when this integrated approach was employed. Teachers accepted Prescriptive Teaching as an improvement over other methods of organizing educational services for the child. It was generally regarded as a practical, effective approach to use within the public school system. It used existing personnel and required the development of basically one skill, the translation of medical, psychological, social, and educational diagnoses into educational prescriptions. Although it provided an improved method of mobilization of services for the exceptional child, its most important contribution was to the much larger group of less severely handicapped children who were retained in regular classes.

(2) Program Improvement

Program improvement resulted in more meaningful educational classification of exceptional children. As a result of the emphasis on specificity and educational relevance,

segregation of children into special classes and integration with regular classes was based upon situationally significant educational criteria. In this way Prescriptive Teaching has become part of a trend toward more meaningful educational programs. Traditionally we have used medical or psychological classifications such as emotional disturbance or mental retardation. Recently we have seen some educational classifications, such as learning disorders and educationally handicapped. Prescriptive Teaching is part of this trend toward educational relevance.

(3) Professional Development

Prescriptive Teaching achieves therapeutic results through educational means and supports development of teacher competencies within the educational system. It establishes a rationale for teacher behaviors on the basis of our best contemporary knowledge of the teaching-learning process. It facilitates the incorporation of new materials and techniques and provides the kind of feedback and on-going evaluation that keeps the educational program in dynamic balance while positively reinforcing the effective teacher behaviors. It is through this process that we can establish a realistic model of the processes of teaching and learning and thus a sound structure for the educational profession.

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CLINICAL EXPERIENCES WITH THE MULTIPLE HANDICAPPED
CHILD AND HIS FAMILY

(on "Sharing Direct Service Experiences
with Implications for Working Families")

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David is a fourteen-year-old boy, who, two years ago suddenly became deaf. He had been a child who had multiple physical handicaps, resulting from German measles which his mother had suffered during the second month of her pregnancy. He had a cataract in one eye, making him almost totally blind in that eye. He had a congenital heart defect which was repaired when he was five, partial deafness in one ear, and in addition, some diffuse motor coordination problems of a rather non-specific nature. He had been attending special schools for the physically handicapped for many years although, before he became totally deaf, his handicaps were not really too obvious to others.

Prior to becoming deaf he was socially a very withdrawn boy. He had few friends, was quite immature and tended to limit his world of involvement to his parents and brothers. His mother was a friendly, warm, but over-protective person who enveloped David in a maternal matrix

and who saw little reason why he should grow up or grow away from her. David's father was himself a very withdrawn, almost hermit-like man who had intense feelings of inadequacy.

David, who has an IQ of somewhere above 140, was referred initially because of his inability to learn to lip read. His speech therapist thought there was an emotional factor involved in the "block". I took David into individual treatment and also saw the parents individually and co-jointly. Treatment with David focused around his feelings about himself. He had always felt he was imperfect.

The first memories of his life involved thoughts of the large scar on the side of his chest where the heart surgery had been performed. He felt as if a slice had been taken out of him, "Like a watermelon," he said. Because he had a cataract in one eye, he was always unable to judge distance well. He often stumbled and, of course, could not catch a ball well. He could not play contact sports because he couldn't judge distance. He was impaired also from the auditory standpoint. Because of the hearing deficit in one ear, he found it difficult to tell the direction of sound adequately. Because of his fear that his scar would "rip open" and his heart might stop, he further limited himself physically. So, from his earliest

years he had the feeling of being very different, vulnerable, weird, and incomplete. He grew up looking at the world as an outsider, except at home where he was accepted by his mother, but this was a problem, too. His mother, who had little joy in her relationship with her husband and who had two other active boys, interested in all kinds of outside activities, turned to David for comfort and enjoyed the fact that he needed her and was with her most of the time.

When David suddenly and unexplainably lost all hearing in his good ear and the rest of the hearing in his already damaged one, making him totally deaf, the withdrawal became more intense. By the time I saw him, adolescence had hit and he became interested in girls from afar. He had no idea how to deal with them. This made his feel worse. I began to learn how really difficult it is to be deaf. For example, when a girl says, "I love you" on a note in class, most fourteen-year-olds see it as if it were to say "I like you". David, on the other hand, thought the girl might really want to marry him and didn't know how to handle it. So he sent a note back saying he was too young to marry. The kinds of things that kids learn from each other, the lingo, the jargon, how to play it cool, and so on, these things Dave was not able to pick up. Dave had not picked this up before his deafness because of his with-

drawn existence and now he was unable to pick them up at all. He began to establish a relationship with me and we could talk over these things which he was able to let me know were on his mind. I worked very directly with him, giving him advice and specific suggestions. One of the things that came out as treatment progressed was an intense fear that he could almost not even admit to himself. This was the fear that since he had had one bad ear, and then the other had gone bad, might it not be possible that since he had one bad eye, the other would go bad as well and then he would be totally isolated from the world. The feeling was that he was on the brink of total isolation. Just being able to talk about this somehow seemed to help. Also, we got out anatomy books and tried to figure out anatomically what was realistic to worry about and what was not.

Along with working with David, it was important and necessary to deal with the parents. The mother had to be helped to see that David could be allowed more independent action than she had felt he was capable, and this meant giving her someone to turn to. This is where father came in. I saw him for awhile individually and many things came up. He was much like David, a very shy, self-conscious man, who felt that his final failure in life was the production of an imperfect son and furthermore, his

inability to communicate and establish a relationship with this boy was the crowning blow to him in terms of his feelings of adequacy. I dealt with the father, first just in terms of establishing a relationship. For this man, this was the first relationship with another man that he had really ever had. The first time he had ever discussed any feelings that were strictly his. Next, I began to focus on the relationship between him and David, helping him to see that David wanted and needed him. This was indeed true, but David felt that his father was totally and completely removed from him. I began to point out things they could do together, places that they could go during the weekend, etc. David had interpreted his father's shyness as not caring and thought his father was displeased and disappointed with him and wanted nothing to do with him. David thought that father saw him (David) as a failure, whereas the father thought that David thought of him (the father) in the same way. We met together occasionally to help them with these issues and the father's relationship with David began to improve. Although it improved, it needed constant prodding, reinforcement and re-evaluation so that both of them did not slip back into their old ways. With regard to the mother-father relationship, almost the same situation had developed. Both feeling that they were failures. Sharing some of these feelings

and also sharing feelings about each other on many other levels helped to improve this relationship so that mother could now let go of Dave a bit more. I present this as if it were easy, but, of course, each step along the way was difficult and required constant reinforcement of all the parties involved.

One more facet of the problem occurred at school where David had been an exceptionally well behaved and excellent student. During the time that David was withdrawn and before treatment, he was a "model student". He was so bright that he needed to pay attention only 15 to 20 percent of the time in order to keep up. The rest of the time he was day-dreaming about science fiction. As he became more tuned in on things and less withdrawn, he became more aggressive. He became angry about missing so much, and he was mad that they didn't teach to him (he was the only deaf boy in the class) and he became demanding and raised his voice often. (David could never tell just how loud his voice really was.) The people at school began to fear that David was like a keg of dynamite, ready to break loose. They had to learn that this was not a bad sign, but a good one and in a short time, as David became more effective in communicating and in making his feelings known, he would quiet down a bit, but that he would never again be quite so passive, shy and frightened, nor would he be quite so easy

to handle. Things did subside a bit when they learned, firstly, that David could control himself and he was not headed for complete chaos. Secondly, it helped when they learned there were ways in which to deal with David, ways of letting him be the big dissenter and complain, and yet not disorganize the classroom. For example, we allowed David to have a ten or fifteen minute session each afternoon with the counselor where he could say what he felt about the various teachers and could raise his voice as much as he wished. With that outlet, he could control himself a bit more in the classroom during this "coming out period".

I will discuss David's problems and the implications later, but let me present a few more cases. How about the psychotic retarded, the psychotic aphasic or the psychotic deaf child? With these children one of the major problems before we can go any further, is accurate diagnosis.

Bobby was a boy who had been at Camarillo State Hospital for four years. He was so unreachable and psychotic that no one had formed a good relationship with him. He spent long hours in the corner doing nothing except flicking his fingers or flapping his arms. At times, he would warm up, but only briefly. Most of the time, he spent tearing bits of paper. He would not sit still really long enough to complete any task so it was difficult to make any kind of

intellectual evaluation. He appeared profoundly retarded. We decided one day to figure out how long it would take Bobby to learn to open a cupboard with some paper in it. The paper was there so he could tear. He learned quickly. Then we put a box inside of the cupboard. We gradually made it more and more difficult for him. We found he could learn to open a number of boxes of rather simple design in sequence, to get the paper, but he could not do the more difficult ones. This was the beginning of a diagnostic evaluation. This evaluation was possible for two reasons. One, the teacher was one of the few people Bobby really liked, and two, he knew something he really wanted; that is, he wanted to tear the paper and we could motivate him. Then we were able to realize that Bobby was somewhat brighter than we had given him credit for. The question then occurred, if he was not all that retarded, why no speech? Could it be purely for psychological reasons that speech had failed to develop? We knew that Bobby was psychotic; could that explain the whole thing? One day in nursery school, the teacher, who by now had come to be really the closest person to Bobby during the entire period of his hospitalization, made an amazing discovery. She called me over. Bobby was standing in front of her and she was talking to him. She looked sideways and her eyes pointed toward a hose on the ground, and she asked Bobby

to bring the hose to her. Bobby immediately bent over and brought the hose. Then she indicated with her eyes, and by a movement of her head, that she wanted him to bring her a block of wood lying on the ground on the other side of her and he immediately did that. Then the items were placed back. She looked directly at Bobby and asked him the same questions again. Bobby was totally confused. He moved from one place to another, but had no idea of what was being asked. This, of course, was a strong indication that Bobby suffered from a receptive aphasia. He could hear words, but most of them made no sense to him whatsoever. Had this aphasic boy been diagnosed correctly earlier, who knows how much better his chances might have been. What would have been the situation with regard to the retardation and would we have had a better chance to deal with his severe psychological problems or would the psychosis have developed at all?

Another diagnostic problem: Alvin was a boy who was so terrified when he came to us that one could not approach him without his screaming and wailing. As time went on, he became more sure of us and our relationship with him allowed us some physical closeness, then we could see this boy really could not carry out implicit or explicit commands, nor could he really understand on any level near normal. We had on our hands a severely retarded boy, with a psy-

chotic overlay, but we were not even able to begin the evaluation until a relationship was formed. Adequate recommendations to the family with prognosis could not be formulated till then.

Ella is a seven-year-old girl who came to us one and a half years ago, with a history of a normal birth and delivery, and a fairly normal first five months of life. She was a responsive newborn, but between six months and two years, a series of horribly traumatic events occurred. When she was six months old, her parents, who were living in Israel at the time, decided to move to the United States. This threatened to separate the mother from her parents and within a matter of a few weeks, the mother suffered her first paranoid-schizophrenic break and was hospitalized for about a month. After her return home, the parents continued with their plans for the move and did, in fact, leave Israel to come to the United States. The father left his parents, a job, and a profession and came to the United States to find loneliness, almost no chance of work and severe financial distress. In addition, Ella's mother suffered another psychotic episode after coming to this country. This was when she learned that her father had died in Israel just after they left. A series of hospitalizations and psychotic episodes by the mother accompanied a gradual and progressive down-hill course by Ella, to the

point that when she came to us in the hospital at the age of five and a half, she had no speech whatsoever, she screamed and banged her head violently against the wall when anyone even so much as looked at her. She ate hardly at all, and tube feeding was almost necessary. She was unable to walk and had to be carried everywhere she went. Since that time, Ella has done well, but, of course, still remains a severely disturbed girl. The psychosis is still present, but to a less marked degree and there are severe gross motor problems as well. Work with the parents has been infrequent, often by phone. We have had rare interviews. This is not as we would have wished. Because of the scarcity of social work facilities, the poor financial situation of the parents and the mother's fear of any therapeutic involvement, our contact with them has been limited and we have aimed our work with them in four areas:

- (1) To keep the mother away when she was openly psychotic;
- (2) to help the father deal with mother at these times and support him in his ordeal, with his two sick family members;
- (3) to help them when they did visit Ella, (Our staff members have often gone with them on their visits on Sundays, so as to be able to help them deal with Ella's outbursts and help calm mother when she becomes upset. Primarily, this is to teach them how to deal with their child.); and
- (4), probably the most difficult job, to prepare them,

(this essentially childless couple), to allow Ella to go into a foster care home. This has been no mean task, but it has been accomplished even in the face of the mother's open and frequent paranoid psychotic episodes. This has been accomplished through the fact that she now somehow has confidence in us, confidence that we really are on her side and are working for her and Ella.

Well, these are merely some clinical examples of a few of my experiences with the multiply handicapped child. For a few minutes, I would like to speak on a bit broader terms. One could make a rather coarse simile and look at children growing up as flowers planted in soil. If the seed is perfect, the plant will grow well. Even if the sun is not out for a few weeks, or if the soil is not fertilized regularly, it may show some effects of this mild neglect, but the final plant will probably be sturdy. It will grow well, unless it really is parched and almost totally shut away from the sun. Contrast that with the situation where the seed is imperfect when planted. It may be, of course, so imperfect it will not grow under any conditions or it may be damaged, but can grow if almost greenhouse conditions are obtained each day. This, it seems to me, is the situation in which our multiple handicapped children grow and we find, of course, that we have far from greenhouse conditions available to help us with their development. The

impact which the deaf child, for example, born into a happy, well functioning family produces, can be felt forever within the family setting. First of all, the period of uncertainty, the denial of the problem -- there is nothing wrong, there are various doctors, trips from one doctor to another, guilt, blaming the doctor, blaming each other, the ambivalence toward the child -- this is when the soil becomes a bit unfertilized. The embarrassment the parents suffer when they take their children out in public. The conflict between the parents which continues producing less stimulation for the child, more anxiety, etc. All of these factors which I am sure you know quite well lead even normal parents to react with fear, anxiety and hostility toward the child, society, and toward each other. These are far from greenhouse conditions which we might wish for our damaged seed.

What can we do with these families? One possibility, we can use the individual approach to them as I did with David; to find and deal with some of the core problems. I could get the parents to share their feelings about this and for the first time in their lives they were able to communicate with each other. This comes through the acceptance of these people by us. We can accept them and their problems and help them to break their silence. The second way of helping is by merely accepting their child. For example,

how important it was for the mother of an autistic child, not only to be accepted by me, but also to be accepted by the nursery school teacher. These people are often accepted by physicians and professional people used to working with the emotionally disturbed child, but when they are accepted in a classroom of normal children this is fantastically important. The fact that my patient Billy was accepted in a nursery school for normal children has made a tremendous amount of difference in his family's feeling about themselves and their child. Next, we can, just as with Ella's family, be patient while they accept us. We don't push. We let them use us and accept us in their own good time and then help them to do the thing which they must do. In Ella's case, it was, of course, to give up their child.

One of the most gratifying experiences at Camarillo was with the family of a little severely disturbed child, with minimal cerebral palsy involvement but serious psychological difficulties, who had become gradually more of a behavior problem after the birth of a profoundly retarded and physically impaired cerebral palsy younger sister. Our worker worked with the mother and with the daughter. The work with the mother was primarily to help her to allow her youngest daughter to leave the home and go into an institution. Then she had a fighting chance to deal with our patient. We can help by providing and directing them toward

facilities where a frank and complete evaluation can be done, and by helping them to accept a recommendation. An evaluation is not just a presentation of the situation and of the facts, but also, it means help for the parents in accepting the evaluation. I never have a one-meeting feedback for parents like this, but always meet two or three times so I can help them to deal with the impact of the evaluation. We can provide appropriate and realistic (by that I mean geographically, financially and psychologically realistic) school recommendations. So many recommendations to parents are unrealistic or inappropriate. Next, augmentation of the school program with good backup for the teachers and principals. How fantastically important this is was brought home recently as we had a multi-disciplinary meeting for a child we had placed in a small mountain community in California. With adequate backup, all of the members of this therapeutic team were able to do beautifully well. We can help with appropriate physical care, appropriate medication (psychotropic or otherwise) and individual treatment when necessary.

Lastly, I should like to say, help really means being a person with these people and doesn't mean sitting in an office or a playroom. It means getting into the home, getting out on a limb, making suggestions right or wrong, but doing something. Most of these parents are terrified

into almost a catatonic state of helplessness, and someone who cares and can act means a great deal.

TOWARD DISPELLING THE MYSTIQUE OF LEARNING
DISABILITIES: "THE MYSTIQUE IS A MISTAKE"

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As the designation "learning disabilities" has begun to emerge as a significant educational entity, concern has arisen in many circles over the mystique that has developed around these children and their disabilities. In the early years of the Learning Disabilities movement, there was no legislation at the State or Federal levels which authorized special education services for the child who does not learn. It was necessary in some states in the 1950's and early 1960's to concoct a diagnosis, perhaps as in Illinois, of multiple handicap -- then services could be provided in the public school under the same reimbursement plan as other handicaps. The usual route for the administrator who really cared, was to have the psychologist test the child and declare him educationally handicapped, and emotionally disturbed. Then, the parents would be referred to a selected pediatrician or two who would be willing to declare him possibly brain damaged. Then, armed with this diagnosis of multiple handicapped, special teaching could be provided under the Special Education Legislation of the state.

This lack of proper legislation, plus much professional jargon, has led to an aura of mystery developing around these children. Teachers began to think that these children constituted a "new" problem. They began to think that this child was so different that he did not belong in their classes. The mystique which has developed about this child has made teachers afraid to teach a child with an abnormal electroencephalogram, with "14 and 6 spike seizure activity in the left parietal lobe". Teachers did not realize that these children and their problems are not new! They have always been in our classrooms. Teachers used to describe these children as having a "mental block" - - -. Now, in 1968, the children are the same, their problems are the same. All we have done is to switch labels. In doing this, however, we have created a mystique which has proven to be a dis-service to the child. I am convinced that the mystique is a mistake.

In an effort to dispel some of this mystique, one can turn for inspiration to one of the great literary masterpieces, The Holy Bible. In Exodus, Chapter 20, verses 2-7, are found the Ten Commandments, which can be rather freely translated into the fifteen-Ten Commandments of Learning Disabilities. After reviewing these precepts, the Concordance, will be reviewed, as it is necessary for the proper understanding of Exodus, Chapter 20, as freely translated.

The Fifteen-Ten Commandments of Learning Disabilities

1. Thou art a member of a most honored profession charged with the responsibility of teaching all children. Thou shalt not put false gods before thee, whether they be neurology, psychology, psychiatry, pharmacology or electroencephalography, expecting them to assume your charge: to teach.
2. Thou shalt not take my name in vain. I am a child who does not learn. Thou shalt not label me with such epithets as brain damaged, dyslexic, hyperkinetic, or minimal brain dysfunctioned.
3. Remember thou that I need to be taught how to learn what you want me to learn.
4. Honor my abilities as well as my disabilities.
5. Remember that children who do not learn do not do so for an infinite variety of reasons. The least likely and most difficult to document at this stage of knowledge in the science of neuro-anatomy is that which attempts to relate the non-learning to the condition to the brain itself.
6. Thou shalt not over-estimate nor under-estimate the severity of my problem. Thee do not yet know the prevalence of learning disabilities in the public school population.
7. Thou shalt not forget that severe learning disabilities is not a dichotomy. The child does not either have it or

not have it like measles.

8. Thou shalt not get bogged down in the organic -- not necessarily organic controversy (the purist-pragmatist controversy).

9. Thou shalt not engage in professional haggles over whether this child is emotionally disturbed or brain damaged.

10. Thou shalt never again list a set of characteristics of children with learning disabilities. They are now acutely aware of the fact that each child with a severe learning disability is idiosyncratic unto himself.

11. Thou shalt remember that the diagnosis of severe learning disabilities is by its very nature temporary and ephemeral.

12. Thou shalt not covet more research base to your educational practices than exists in fact.

13. Thou shalt remember that it is very easy to tell parents what not to do, but very difficult to tell them what to do.

14. Thou shalt not indulge capriciously in the referral game, but shall judiciously check each agency before referring parents to yet another source of help.

15. Thou shalt remember that these children do belong in your classroom. They do belong in your school.

IMPROVED SPECIAL EDUCATION SERVICES FOR VISUALLY
IMPAIRED CHILDREN WITH MULTIPLE HANDICAPS

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Approximately 12 years ago a social worker for the pre-school blind children in Los Angeles County asked if we would take several blind aphasic children in our Center. "But," we said, "we know nothing about working with blind children"! "Why is that so special?" was her reply. "We don't know anything about working with aphasic children"! This is the dilemma of the multiple-handicapped child. We need to ask ourselves:

- What kind of a facility can encompass the multiple-handicapped child?
- How can these child be appropriately evaluated and programmed?
- How can community services be involved?
- How can the parents be effectively included?

Allow me to describe my facility briefly as a stepping stone to these other considerations.

The Speech and Language Development Center was founded 14 years ago as a Center for children with speech and language disabilities -- primarily for those children considered to have neurological involvement. Children were seen on a twice a week therapy basis -- parents were coun-

seled and a parent group founded. We discovered very early that the problems rarely came simply as a speech and language problem -- that the aphasic child of literature practically never existed in pure form. We received then, as now, children with multiple problems -- peripheral impairments in hearing and vision, motor incoordination, emotional involvements, epilepsy and questionable retardation. One of our earliest referrals in the multiple-handicapped area, was a severely visually impaired neurologically involved, emotionally disturbed boy of 5 who had developed no speech!

Our program did not become effective, however, for these children and many others until we were able to establish a daily program and many ancillary services. Today our program consists of daily sessions for children from 2½ years until 21. All of the children in the school age bracket come to us under California Education Code 6871. There is an adjunctive therapy program for those well situated in the public school setting. Our staff consists of nine full-time speech clinicians, eight educational aides, a part-time psychologist, psychiatrist consultant, an adaptive physical education teacher and a consultant in this field, as well as five volunteers and three graduate students receiving clinical experience. While the daily groups are in small classrooms, each child has an individual therapist, and a child not able to modify in behavior is in an intensive

individual program. This is the program and staff, who, together with many advisory groups, serve approximately seventy children on a daily basis and one hundred and ten children in adjunctive therapy.

What brings a visually impaired, language dysfunctioning child to our facility? Failure to find adequate placement in other facilities because of the severity of the several handicaps. Aberrant behavior has usually been a factor -- failure to communicate always is. Let me mention two children, who, in their atypical problems, represent the children who come.

Laurie, age 8, has been known to our facility since age 3, having first been referred to us by the social worker for the pre-school blind. Diagnosis: blindness, autism, complete failure to communicate. We did not have a pre-school program for Laurie at the time, so we referred her to a nursery school for the blind, in Los Angeles, while we continued to see her for speech therapy. Our twice-a-week therapy was insufficient -- last year she was returned to our daily program. Here Laurie is in a varied program from 9 a.m. until 3 p.m. She spends part of her time in the academic readiness program, two hours with her worker who is part of the psychiatrically directed program, a half-hour in the adaptive P.E. program (or perceptual-motor program) and forty-five minutes with her individual speech

therapist. One of our teachers, blind himself, is aiding the therapist in some preparation for braille for Laurie.

Mona, age 10, was referred to us by the physician in charge of her care and by the social worker to whom she was assigned for placement in the community in a foster home. Mona had been placed in Camarillo at age 6 after an early childhood of extreme deprivation. As a visual and hearing impaired child, she was hampered in learning. As an emotionally deprived child, she was not amenable to usual learning situations. At age 10 there was no speech forthcoming. Yet, an awakening of interests had convinced many observers of her capability to learn. A Leiter administered at our facility placed her in a bright normal category of intelligence. The foster parent sustained the impossible; we sustained broken windows, kicked shins. At first, Mona was placed with a worker in the behavior modification group. As she was fed sensory stimulation, her behavior changed rapidly. Concentration was placed on learning tasks of the pre-school level, with her individual therapist and with a series of mothers who act as "tutors". She has been removed from the behavior modification group.

Essentially our program was not effective with these children or any of the multiple-handicapped children until the following facets of our program were established:

1. Initial evaluation and diagnosis

2. Individual therapy
3. Pre-school program (ages 1-7)
4. Daily School Program (ages 6-21)
5. Psychological assessment
6. Psychiatric assessment
7. Behavior modification group
8. Perceptual Motor Training
9. Parent counseling

Programming for the multiple-handicapped child is complicated and must often be fluid. A simple concept for programming is based on these broad disabilities of the child:

1. Can this child relate to his environment or people in it? (things, people effectiveness)
2. What is this child's motor ability? (Can he act so that he can learn?)
3. What sensory intake does this child use? (peripheral, perceptual)
4. What use does he make of his intake? (association)
5. Can he convert what he knows into communication? (Does he possess the symbolic process? i.e., know that something stands for something.)

Summary

Evaluating the effectiveness of a program such as the one that exists at this facility we have found that the following factors have appeared to play a part:

1. Professional background of the therapists involved
2. Heavy community involvement
3. Parent participation
4. Availability of California Education Code 6871 for private facilities

There is a commonality of language process which bridges all development and learning stages. In understanding this process and its relationship to perceptual development, we find, in regard to all children regardless of limitations or disabilities, rather than conceiving of children as specifically handicapped, we can consider them as children with specific deficits in language, learning and behavior. Our primary goal is to work for change in the child and for preparation for another setting. When an entire staff is aware of the goals involved, a convergence towards these goals takes place. In evaluating the growth of the program over the past 14 years, it becomes apparent that we have often tried programs without actually knowing their potential until we have worked on them in our setting. We have been encouraged to try such programs by the wholehearted support of the community and the public educational facilities.

ADMINISTRATION AND SUPERVISION OF PROGRAMS
FOR MULTIPLY HANDICAPPED CHILDREN

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I am most happy to have this opportunity to share with all of you some ideas and considerations in the area of administration and supervision of educational programs for children with multiple handicaps.

One of the most important questions in operating a program or activity is the basic and fundamental question: What are you trying to do? This question is easily answered in vague and generalistic terms. It is less easily answered in specifics. A basic underpinning, inherent in answering this question is the involvement and philosophic awareness of the individual.

In order to initiate our special education program for children with multiple handicaps, a series of events must take place. Each of these events is followed by or preceded by an activity or group of related activities. Here is the traditional pattern of events which might take place:

1. Children with Special Needs Exist in Community X.
For us, these are multiply handicapped children.

The Activity: Seek ways to meet the needs of these children. Communicating needs of children for a special educational program.

Communication from: Parents. specialists who encounter the children in diagnosis or treatment, and others.

Communication to: A man who, by training and experience, has shown his ability to start and run educational programs -- an Administrator.

2. Administrator Agreed to Study the Needs

The Activity: Gathering of data to provide preliminary answers to relevant questions.

Study of Data: What are their problems? What are the causes of their problems? What does research say about meeting their needs? What do the authorities say? Are there model patterns or programs to follow? What kinds of service are indicated? What personnel and facilities might be required? What might it cost? Are there laws and regulations to authorize and facilitate programming? Are there fund sources? During this search, the administrator utilizes the services of many specialists to gather data. He also enlists administrative support if preliminary study shows sufficient need and opportunity. The result of this effort is Event 3, a written document.

3. Major Need Dimensions are Outlined:

Request for Administrative Support is Tendered.

Activity: Takes place with group who originally communicated needs.

4. Agreement is Reached to Form and Operate a Program

Activity: How the work begins. Planning requires first the determination of overall goals (from preliminary proposal, plus further study). Setting of limits of endeavor, outlining of major policies or rules.

Decisions to be made regarding: What will be done, for whom, by which kinds of persons, in what facilities, with what materials, how often, and for how much money? These are most often generalizations for planning purposes to establish a base for more detailed planning.

5. Overall Goals, Limitations, Policies are set.
This is a written description.

Activity: Much administrative work and planning activity now translate goals within limits and policy to a description of services, people, facilities, materials, and arrangements.

6. Written Program Description, Operational Plans: Staff, Services, Facilities, Budget

Activity: Program description is finally revised and submitted to proper authorities for approval and funding.

7. Program is Authorized and Funded

Activity: Planning coordinating, integrating, and assemblage activities toward operation. Screening children for eligibility, staff for employment, building construction, remodeling, purchase of equipment and supplies, operational planning.

8. Assemblage of Staff, Facilities, Materials, Plans

Activity: Pre-operational activities, development of schedules, adjustments, details.

This is a theoretical model, of course. The actual events do not always take place in the order you have seen, nor in the detail I have explained. For example, the decision to plan a program for multi-handicapped children may take place only after the State Legislature has appropriated designated funds toward the operation of such a program. Nor do the same people always administrate all the way through the procedure outlined.

This is a somewhat traditional model. It is authoritarian in concept. It is based on the assumptions that "administrators know best, or can assemble specialists or

authorities who know best", and "pick out the best plans, goals, and procedures from the recommendations of such authorities".

This model has been in use for some decades in initiation of educational programs for children. It works, to the extent that it does get a program started. However, there are some serious obstacles which lie in the way of the planners. Let me list some of them for you:

1. There is little or no research data to show that one combination or program of planned educational and related activities is superior to another planned approach, in meeting the needs of handicapped children who have multiple impairments. In fact, there are very few programs at all for these children.
2. From this general statement, it follows that, for multi-handicapped children:
 - a. There are no curriculum models of proven superior value;
 - b. There are no teaching methodologies of proven superior value;
 - c. There are almost no Master Teachers of multi-handicapped children and those who do exist do so within the criteria of a particular program, not under general standards of excellence;
 - d. There are no training programs to produce Master Teachers, except those trained to function within an established program. (To employ such a teacher is to employ the Program.)
3. Traditional diagnostic data contain information on causality and degree, and dimensions of impairment. They do not readily translate into program activities which meet the needs of multi-handicapped children.

From the very beginning, we have avoided actually answering the most basic questions of all: What things does the child need to be able to do and how can we teach him to do these things? What should he stop doing?

I suspect that in all too many cases, the evaluative questions which the administrators would ask would appear something like these, listed in order of preference:

OPERATION: IS IT RUNNING SMOOTHLY?

1. Do the books balance?
2. Are the building and equipment holding up?
3. Is the staff happy or satisfied?
4. Are the parents happy or satisfied?
5. Are the children happy or satisfied?

OPERATION: IS IT RUNNING EFFICIENTLY?

1. Monthly cost comparisons favorable?
2. Are reports from supervisors positive in tone?
3. Number of activities -- how many?
4. Approval from significant others?
5. Are the children learning anything?

Evaluation of the children's "learning" is usually the responsibility of the teacher and used to satisfy the parents. We also may provide parent counseling to help parents accept the limitations of their children and to

be satisfied that the school program isn't doing any more to help them.

In planning, operation and evaluation of a program for children with multiple impairments, I find that the traditional authoritarian model is not a working model. It begins from the wrong direction and proceeds in the same direction.

I believe that the traditional model is administrator-centered, missing the basic purpose of education for children, and in particular, for children with multiple handicaps. For me, the basic purpose of an educational program is to enable the multi-handicapped child to become more functional in his environment. We can only do this by studying the child in his environment, obtaining data of his behavior in that environment, and using those data to operate teaching behavior which attempts to reduce undesirable responses and increase desirable responses toward more effective functioning. We continue to observe the behavior -- this tells us whether or not our method is working.

The most critical person in the operation phase of the educational program is, in my philosophy, the teacher. And the teacher exists only because of the needs of the handicapped child.

Let us define learning as meaningful change in behavior

in responses to environmental demands. The teacher's prime function is to arrange a learning environment and produce opportunities and enhancement toward desirable change reinforcing consequences, and toward reduction of maladaptive behaviors through environmental and opportunity manipulation and withholding of reinforcing consequences.

I am not saying that the teacher is the most important person in the program. I am saying that the child is. And the teacher is the direct interactor with the child. By "teacher" I mean speech therapist, occupational therapist, classroom teacher, or any of the individuals who interact with the child for the purpose of changing his behavior through experience.

Consequently, it is the responsibility of Administration to focus all efforts toward facilitation of the teacher's efforts. It is Administration's job to facilitate the teaching. The basic purpose of the entire program is to facilitate the teaching behaviors toward desirable changes in the children. Materials, equipment, facilities, services, staff and administration must be aimed toward that end. Traditionally, they are not. The teacher has to fight for what is needed in the classroom.

All of this is not the value of administrative activities described earlier in this presentation. The point is that the basic reasons for their existence in the traditional

pattern are of unknown or little relationship to what is actually done by the teacher with the child. In the traditional method, educational planning is based on educated guesses as to what we ought to do to improve or help handicapped children. If we base such guesses on theoretical hypotheses, we call it an experimental program. If we base our guesses on traditional diagnosis, we call it diagnostic-prescriptive teaching or psycho-diagnostic teaching. But diagnosis does not lead to teaching methodology.

Let me give credit to Dr. Richard L. Schiefelbusch for some concise observations concerning this rationale: the reference is his introductory chapter to the book, Methods in Special Education, Norris G. Haring and Richard L. Schiefelbusch, editors, McGraw-Hill Book Company, 1967. Here are those observations, in colloquialized form:

1. Educational planning must be based on information which is relevant to the child's needs. This information is the basis of planning the process steps in education and treatment.
2. Diagnosis is the procedure of obtaining information. The problem is to employ diagnostic procedures which are linked to the methods of treatment employed.
3. Traditionally, the information collected on

handicapped children includes a developmental history, a medical history, a family history, a profile of performance levels, and an educational achievement level. Such information does not translate into instructional objectives as described by Robert Mager, or into planned teacher activities to change child behaviors (cause or assist learning to take place).

4. The description of disabilities in behavioral terms suggests instructional procedures.

Schiefelbusch describes functional analysis of behavior as a promising approach in planning, operating and evaluating programs for handicapped children. In essence he is saying, "Here we have children with problems".

1. What we really mean is problem behavior, or maladaptive behavior.

2. To plan an educational program, let us study and analyze the relevant behavior. Testing is not as valid a behavior sampling method as functional analysis of behavior because a test provides only one or a few samples. Samples of behavior taken during task performance over a number of time intervals or a continuous sampling of behavior considered relevant may achieve 100 percent face validity. That is, it may more accurately answer our questions:

What can he do, and what does he do?

3. Functional analysis of behavior does more than provide validity. It provides the data for formulation of instructional plans and procedures. Included are the antecedent events: What comes immediately before the target behaviors? The response behaviors: What does he do in response to the antecedent? The contingency system: What happens to him as an immediate consequence of his behaviors? And the consequent events. A baseline for the frequency of the target behavior responses provides for quantification of behavioral change.

Let's hypothesize that a group of parents of young deaf-blind children come to us and say, "We hear that there's federal money and state money to initiate and operate an educational program for pre-school multi-handicapped children. Our children need help. We need help. Will you write up a program application? We will pay you".

This is only an intellectual exercise, in today's meeting, but this could be just the way it happens. So you agree to take a six-week's leave of absence from your job and take on the project. It's going to be under Title VI-A. The first step will be roughing out the project proposal. Before we can make out a budget or such, we must write the program outline. Title VI calls

it Description of Project Activities.

Title: Project to Devise and Operate a Program for Pre-School Deaf-Blind Children

A. Description of major program and project activities and their basic features. The major activities will be (1) the formulation of, and (2) the operation of a program of activities in the following general need-dimensions of deaf-blind pre-school children: (a) cognitive development, (b) language development, (c) physical development, (d) emotional development, and (e) social development. The basic features of the program are as follows:

1. Acquisition of necessary supportive background information on each individual child for whom the program is to be devised: medical history, developmental history, family history, assessment of cognitive functioning, emotional development, social development.

2. Formulation and operation of an observation team to perform a functional analysis of the relevant behavior of each child in his home environment, toward the end of acquisition of information regarding:

- (a) the parent's approaches to the child's responses and

(b) the child's approaches to the parents' responses

i.e., task analysis of operant behaviors of parents and child in terms of stimulus events (antecedents), response behaviors, contingency systems, and subsequent events.

3. Involvement of teaching staff (teacher, language therapist, psychologist, physical therapist) and consultive staff in the functional analysis process.

4. Formation of preliminary hypotheses concerning the dynamics of observed target behaviors in context of environment (antecedent and contingency systems) for both child and parents.

5. Translation of hypotheses into trial formuli for behavior modification toward more functional responses or decrease of maladaptive responses by teachers and consultative staff.

6. Training of parents in basic concepts and dynamics of operant behavior and behavior modification.

7. Selection of teachers, in consultation with parents and staff, of initial target behaviors and tentative behavior modification techniques for each child in the program. Criteria of success set.

8. Determination by teachers with consultation with parent and staff to require materials, facilities, services necessary to put into effect modification techniques.

9. Continual acquisition of behavioral information in target behaviors during application of modification techniques as evaluation of progress toward success criteria.

10. Periodic reassessment in terms of behavior data toward criteria and adjustment of modification techniques.

B. Criteria to be used in selecting participants: reality decisions; standards of degree of handicap, age, for children; standards of background, ability records, interest of teachers; standards of professional training, experience, consultants, etc.

C. Needs of participants: (needs are goals -- goals are needs)

Children: Generally to be helped to acquire or increase effective behavior in language, physical, cognitive, social activities, and to be helped to decrease maladaptive behaviors in these areas.

Teachers: To be helped to help children change their behaviors through provision of

information, opportunity, environment, materials, services, aimed at providing the maximum of effectiveness in modification of the behaviors of multiply handicapped children.

Consultants: To be facilitated in their efforts to help teachers help children to modify behaviors.

Administrators: To direct all activities toward the facilitation of the teachers' efforts at behavior modification of children's target behaviors.

I think we have gone far enough to convey the message. I must say here that whether or not you select behavioral modification via operant conditioning techniques, doesn't really bother me. You still need to build your program on behavioral terms and prepare your instructional objectives if you want to know the answer to significant questions about your teaching or your consulting or your administering; questions like: Is your program really effective? What are your instructional goals? Are you making progress?

Let me conclude by saying that I view the teacher as an administrator, too -- an administrator of the activities,

situations, environmental events which facilitate learning by the child -- or she may be like the traditional administrator we first studied: fuzzy about what the child is actually learning, but awfully proud of the room and activities going on there and of being an administrator.

In Idaho there are many short formulas for evaluating the effectiveness of an administrator. One is to walk into the building and observe the cleanliness of the lavatories. Clean lavatories -- tight ship! Another is to observe a winning football team and check up on the team's scores for the season. My idea of an evaluation is to try and discover what the teachers think they are trying to accomplish with pupils in their classrooms, and then to spend a lot of time observing the interaction of teachers and their pupils, seeing what the teachers and pupils really do. Most often I judge from pupil behaviors that teachers must not be teaching what they tell me they are teaching! And that final question -- Where are the official Administrators? I guess they are out conferring with the coach about the football team, or in working on the budget. I wonder if this is also true in California?

WORKING WITH PARENTS IN AN EXPERIMENTAL PROGRAM
FOR EMOTIONALLY DISTURBED DEAF BOYS

Robert K. Lennan
Pilot Project Supervisor
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Those of us who work with deaf children share your concern over the problem of the multiply handicapped child. "The full impetus of the problem of the deaf child with additional handicaps began to be felt by schools for the deaf in the 1950's. As has been true in most areas of this profession, there were many years of discussion before actual steps were taken to bring about programs, in fact the problems of accurate diagnosis and knowledge of educational treatment is still in a state of infancy. There is an awareness of the problem and concerns for solutions. It can be anticipated that there will be a tremendous growth in the establishment of programs for multiply handicapped deaf children in the ensuing years". (Brill, 1967)

Here in California the problem has reached the crisis stage as shown by a survey made by Donald Calvert last spring. His study found a total of 984 deaf children under the age of fifteen years with at least one other major handicap that would affect educational placement. Of these

children, 431 had one handicap in addition to deafness, 273 had two handicaps in addition to deafness, and 280 had three or more handicaps in addition to deafness. A projection of the total number of multiply handicapped deaf children in California at the time, resulting from the rubella epidemics of 1964-65, raised this total of 984 deaf children to a total of 1,732 children as an estimate of the number of multiply handicapped deaf children from all causes in California as of May 1, 1968. (Calvert, 1968)

Since 1957, Dr. Richard Brill, Superintendent of the California School for the Deaf at Riverside, has sought unsuccessfully to gain the necessary financial support to establish a unit for multiply handicapped children at our school. Over the past two years we have carried on an experimental program with emotionally disturbed deaf boys under a grant from the U. S. Office of Education. One of the purposes of this experimental study was to demonstrate what could be achieved by multiply handicapped deaf children given the necessary program, facilities, and an appropriate staff-student ratio. I have been asked to describe this project for you today, with particular emphasis on the parent program.

Our experimental group consisted of sixteen prelingually deafened boys ranging in age from seven through twelve,

all of whom had a minimum intelligence level of dull-normal or a performance I.Q. of 85 or above obtained through the use of an objective non-verbal test. No subject suffered from a gross neurological dysfunction as determined by neurological and pediatric examinations. All of the subjects had a history of emotional problems which prevented their successful achievement in schools or classes for deaf children as presently organized. The background of the experimental group is as follows:

BACKGROUNDS OF SUBJECTS

- | <u>N</u> | <u>Educational Background</u> |
|----------|--|
| 2 | Patient in a state hospital for the mentally ill with no prior enrollment in any educational program. |
| 1 | Patient in a state hospital for the mentally ill with prior enrollments at the California School for the Deaf, Riverside, and in a day class for the deaf. |
| 1 | Workshop for mentally retarded children and a patient in a state hospital for the mentally retarded (3 months). |
| 4 | Formerly enrolled in a day class for the deaf but had been excluded because of emotional problems. Enrolled at the California School |

for the Deaf, Riverside, but having severe emotional problems that were preventing satisfactory academic and social progress.

- 8 Enrolled in day school or day class programs for the deaf but referred for admission to the study because of emotional problems that were causing consistent academic and social failure.

At the end of the first year three subjects were able to be admitted to regular classes for the deaf; one subject had to be dropped from the program and returned to a state mental hospital where he had been a patient before being admitted to this program; and one subject died during the summer between the first and second year of the study. The other eleven subjects continued in the study for the second year, and five additional subjects were brought into the study for the second year to maintain a total number of sixteen. Over a two-year period, twenty-one boys were included. At the end of the second year, six more children from the original group were admitted to regular classes for the deaf. Because federal funding of the project was discontinued, it was necessary to return the other ten children to their home school districts. At this time, most of them are not enrolled in any educational program.

We feel that the success of the program can be attributed to the following factors:

1. Small staff-pupil ratio

The normal teacher-pupil ratio in classes for deaf children ranges from one-to-six at the primary level to one-to-nine or ten at the secondary level. A ratio of one-to-four was maintained in the experimental study because of the severity of the behavior problems of the subjects and their widely varying educational backgrounds. The usual ratio of dormitory counselors to children at our school is one-to-sixteen. The ratio maintained with the experimental group was five-to-sixteen. The small staff-pupil ratio permitted a highly individualized approach to help the subjects overcome their emotional and educational problems.

2. Behavior modification techniques patterned after the "Engineered Classroom" as developed by Dr. Frank Hewett (Hewett, 1967)

This provided a structured school program, planned routine, and the planned, consistent use of positive reinforcements to bring about desired behavior change.

3. The use of manual communication

To eliminate the frustrations caused by inadequate

receptive and expressive communication and to facilitate the instructional process, the simultaneous method of communication which includes the use of fingerspelling, sign language, and speech was utilized.

4. Extensive use of "teacher-made" visual aids, including overhead transparencies, 35mm color slides, and Super-Eight movie film as teaching aids

These provided an increase in the amount of stimulus value contained in the teaching materials.

5. Utilization of "teacher-made" programmed instructional materials

The use of programmed materials was consistent with the behavior modification procedures used since they provided immediate knowledge of results and positive reinforcement for correct responses.

6. The development of a cooperative working relationship between dormitory and teaching personnel through the medium of teacher-counselor teams

The team provided a unified and consistent strategy in attacking the behavior and learning problems of the subjects.

7. Parent education and counseling program

The parent program was designed to provide a basic orientation to the problems imposed by the handicap of deafness, to provide instruction in manual communi-

cation which would facilitate more effective communication between the parents and their children, and to explore parental attitudes and self-concepts that might be affecting parent-child relationship and the social and emotional development of the child. The need for such a program became obvious in the course of home visits which were made by the project supervisor and the school's psychologist to carry out evaluations of possible candidates for the experimental study. In every case we found an almost complete lack of meaningful communication between parent and child, a consistent pattern of mismanagement which had led to emotional and behavioral problems, and a general feeling of helplessness and inadequacy to cope with the unique problems presented by the child's handicapping condition. Lippman (1956) points out that "working with parents is a vital part of the structured classroom program. It is essential that parents at home maintain the same general conduct and achievement standards that the school maintains. Otherwise, the child is confused and further conflicted in his attempts to grow and mature". Aside from the need for consistency in carrying out behavior modification and maintaining new levels of behavior as they were achieved, there was a need for effective communi-

cation and cooperation between the parents and the teaching staff. For the child with normal hearing there was countless opportunities for vicarious learning experiences in everyday life through the mediums of television, radio, various printed materials, and conversations with those with whom he comes in daily contact. The deaf child is cut off from these experiences because of his sensory impairment and the resulting lack of verbal facility.

Parents of children who were selected as subjects for the experimental study were informed that their child's acceptance into the program would be contingent upon their agreement to take the child home each weekend and their active participation in the parent program. All of the parents agreed to these conditions, but there was a wide variance in the degree of active participation. In retrospect, I believe that we would have had a higher degree of involvement if we had required the parents to sign a formal agreement. It is interesting to note that the parents of eight of the nine boys who were integrated into regular classes for the deaf took an active part in the program.

I would like to describe the various aspects of the parent program at this time. Initially, a series of two-hour meetings were held on alternate Sundays beginning at

3 p.m. These meetings were designed to provide a basic orientation to the problems imposed by the handicap of deafness and the procedures being utilized by the project staff to bring about behavior modification. Topics discussed were as follows:

1. General overview of the project and the role of the parent
2. A comparison of the language development of children with normal hearing and deaf children and the educational implications
3. Demonstration of techniques and materials used in teaching vocabulary and language
4. Psychological implications of deafness
5. Discipline
6. Description of behavior modification techniques being used with suggestions for their use in the home by parents
7. Panel discussion by deaf adults concerning their experiences as deaf children growing up in a hearing family
8. Explanation of the functions of the hearing mechanism; demonstration of the distorted auditory input experienced by children with hearing impairment using a hearing aid; explanation of various

types of hearing loss and the care and proper use of hearing aids

9. Discussion of dormitory routine and recreation program

Following this initial series of meetings, the second phase of the parent program was initiated, to provide group counseling under the guidance of a licensed family and marriage counselor through a series of ten weekly sessions of two hours each. The California Personality Inventory was administered to the parents and the results of this test were used as a basis for discussion. Role playing and other group therapy techniques were also employed.

Weekly classes in manual communication were provided for the parents on Friday afternoon, following the close of school, and on Sunday afternoon at 2 p.m. These classes were designed to provide parents with basic communication skills which would enable them to communicate more effectively with their children. Each Friday afternoon when the children returned home for the weekend, their parents were provided with a detailed report on the instructional activities which had taken place during the past week with suggestions for possible activities which might be carried out by the parents to reinforce the concepts that had been taught. This report also included a short paragraph on

each child's behavior and academic progress during the week. This provided for constant communication from the project staff to the parents. Parents provided written reports each week on the child's behavior at home and his weekend activities. These reports were most useful in coordinating the behavior modification efforts of the parents and project staff, and as a basis for the vocabulary and language development of the child by his teacher.

In addition, periodic parent-teacher and parent-teacher-counselor conferences were held. These provided an opportunity for a dialogue between the parents and project staff in developing and carrying out a cooperative program to facilitate the behavior modification and educational programs. At the end of these conferences, the parents were given a typewritten resume of the points discussed by staff members.

From the outset we were determined to keep lines of communication open between the project staff and the parents, and to provide them with the basic knowledge and information which they would need if they were to function as knowledgeable working partners in helping to overcome their child's psychological and educational problems. I think that those of us who work in special education are somewhat guilty of conveying to parents the impression that we know what's best for Johnny and if they will leave

everything to us, we will take care of his problems. Somehow I just don't think this is feasible in the case of multiply handicapped children.

Probably the biggest task that confronts us as adults is the role we play as parents, and yet it seems rather ironic that our society makes no provision for formal instruction that will help us to achieve success in carrying out this difficult and challenging task. The widespread annual sale of books such as Dr. Spock's manual on child care and others would seem to indicate the need the parents have for guidelines, or a model if you will, upon which to base their behaviors as parents. In the final analysis, most of us probably adhere pretty closely to the model provided for us by our parents when we were children, and we tend to replicate their attitudes and actions in our relationships with our children. For the parents of a handicapped child there is no model based on their past experiences which they can call upon for guidance in carrying out their parental functions. Guilt by an inability to communicate with the child because of his sensory impairment compound the problem further. Most parents I have talked with have a real concern for their child. They want to help him become a well-adjusted adult who is capable of carrying his own weight in our society. They want a positive plan of action to carry out. They want meaningful

answers to their questions. They are tired of getting the "run around".

I am enough of a realist to accept the fact that we can't get the sort of parental involvement we would like simply by setting up a series of meetings. This is especially true if we want to include fathers who have other demands on their time. Perhaps we should investigate the possible use of new educational media such as programmed instructional materials and single-concept Super-Eight cartridge films in developing a home study program for parents. If materials of this sort were placed in the home, they could have an impact not only on the parents, but on the other members of the family and neighbors as well. Certainly none of us can deny the need for greater understanding of the children with whom we work. In addition, the preparation provided by these materials should help to make our meetings with parents more productive.

There just aren't enough hours in the school day to provide multiply handicapped children with the educational program they need. Their learning experiences must not stop when they leave school at the end of the day. Now, more than ever, we need parents who can function as knowledgeable working partners if we are to achieve our goals.

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REACTIONS FROM PARTICIPANTS

A primary function of the Special Study Institute was to provide time for the members to meet in smaller group sessions to discuss further problems and statements set forth by the Institute speakers and to exchange ideas of special concern. Each of the eight groups consisted of a chairman, whose major role was to serve as a leader of the discussions, and a recorder. The groups met a total of five sessions, each lasting one hour and fifteen minutes.

One of the goals of the group sessions was to provide opportunities to make application of the broader, more general knowledge concerning complicated multiple impairments to specific problems related to the visually impaired. Individual participants were free, however, to relate their discussions to those aspects of the general sessions which they felt merited exploration.

In order to clarify questions and problems mentioned at the general sessions, many of the groups asked the general speakers to participate in the group discussions. This format allowed the speakers to elaborate on points presented at the general sessions and to discuss their philosophies in relation to specific problems of members of the groups.

Because of the heterogeneity of the groups, points of view were presented from administration, nursing, psychology, teaching, social service, and agency orientations. One of the groups divided into smaller sections, which represented each discipline, for brain-storming periods and then reconvened as a group to present the major points of view discussed.

Where quotations are used, comments have been directly reproduced from individual reports, without identifying the particular group.

The recorders' minutes indicated more points in common among the group discussions than uniquenesses. Much concern was for the early identification of children with multiple handicaps. One suggestion was that registration of all children with handicaps should be mandatory. With children identified, there was concern for the dearth of pre-school education and the parental educational programs.

"Pre-school, intensive parent counseling, and individual home visits are essential for visually handicapped children and their parents. There is a need for services from birth through pre-school through all the school experiences. There are only two workers for pre-school field services from San Luis Obispo to San Diego, with a caseload over one hundred".

It was suggested that parents might be given programmed materials such as film loops and a "tutor chest" to help

them work with their children.

The development and improvement of programs and the placement of children in programs most advantageous to their development were recurrent topics of many group participants. Opinions were expressed that often programs are not fully thought-out as to the needs of the children, but receive their impetus because money has been made available.

"When a new program comes into being in a school district, we sometimes start it in an isolated manner. Should we give more time to planning before the program actually goes into operation? The new program needs to tie in with the other services already available in the area. We could do a better job of pulling together the various services. This should be done by the administration, although it is frequently left up to the teacher to do and she frequently does. This kind of planning would save time in the long run".

Questions arose as to whether particular programs, such as itinerant and resource, were recommended for reasons of administrative ease rather than for pupil needs. Such questions developed because of concern for severely impaired children. Often mentioned was need for greater flexibility within programs to make it possible to accept children who do not exactly fit the defined criteria for admission. It was felt that legislation should be less restrictive in its definitions of handicapping conditions, so that children

who did not "categorize" well could be tried in several situations to see where their needs could better be met. There was much good feeling generated about the new legislation for the deaf-blind whose guidelines are broad rather than narrow. Several people from the developmental centers indicated the freedom they had for innovative procedures because of the relatively non-restrictive legislation under which they were created.

"The team approach of specialized teachers, health personnel and psychologists was specifically recommended. Greater utilization of specialized knowledge in the different areas of exceptionality is imperative. All special education teachers should have access to personal consultation with a school psychologist who is employed specifically to work with special education classes".

For the more seriously handicapped child, it was suggested that several districts could pool their resources to serve the children in a self-contained program. A pre-school center for three to five year olds was seen as having valuable assets in programs for severely impaired children. In such a setting, specialized teachers and aides could be present, and integration of the child into play-time in a regular nursery school could be considered. A specialized program for the child in a regular class at age six could be attempted.

"Other possible solutions for the education of children with multiple handicaps were discussed. One idea was that a class of 15 to 20 children be set up with three teachers or more, each representing a major handicap, such as deaf, blind, orthopedic, and learning disabilities. Aides and non-credentialed personnel could be utilized to create a 1:1 ratio. Another idea was to create special day classes composed of any children with multiple handicaps and multiple ADA financial support".

ADA regulations are complicated by teacher qualifications, grouping of handicaps, and financial support.

Groups felt that there is a great lack of communication between organizations serving handicapped children. Families often get no service at all. Other times they are bombarded with too much help. Some participants recommended writing a directory for the State of California and individual counties listing agencies (public, private and denominational) serving exceptional children. Another recommendation suggested that agencies involved with exceptional children should send representatives to speak directly to meetings of physicians. The medical association has a school-health committee.

"The desperate need and difficulty of training teachers specialized in teaching children with multiple handicaps was repeatedly emphasized. Teacher training institutions should emphasize the teacher's understanding and knowledge of teaching methods for all disabilities. This recommendation centered on the inadequacy of a single 'survey' course to create a teacher

competent to work with children who deviated from her 'speciality'".

There were strong recommendations that teacher training curriculum should be revised to integrate valuable knowledge from all areas of exceptionality to ensure the necessary breadth of information and skills for teachers of multiply impaired children. In order to make use of the skills of teachers trained out-of-state, several administrators suggested that an out-of-state person not present her credentials directly to the State, but through an Administrator. If the Administrator wants her badly enough, ways are made possible to hire her.

"Rather than train teachers in many different exceptionalities, teachers might be trained well in the area of learning and learning disabilities. Have teachers understand the learning process and how to teach children. Then they can be trained in areas of exceptionality. Know developmental sequences of learning a concept, and break the teaching into steps. Think realistically. Match program in terms of disability of the child. Etiology is not that important. Take the child from where he is and work with his strengths, not his weaknesses".

In most cases the evaluation of the group sessions were positive in nature. The majority of the members of the groups seemed to like the idea of a free, non-structured discussion where they could voice their views on problems and areas of interest to them. Several people mentioned

how good it was to talk with people without 'school hierarchy problems' being involved. People shared their ideas readily and did not hesitate to express controversial and conflicting viewpoints.

Concerning reactions to the general sessions, some individuals felt that speakers, movies, demonstrations should be more oriented toward the situation that actually exists in the classroom, rather than the optimum situation that was demonstrated, where a one-to-one relationship existed between adult and child, where frequently twenty-four hour behavioral control can be exerted, and also the wealth of ancillary personnel. All these advantages are not indicative of the usual classroom teaching situation. Others reacted favorably to the lack of highly structured lectures dealing specifically with the area of visually handicapped as they felt the need for information in other areas. The application of this knowledge was obvious in dealing with severely impaired children today.

Often institutes are criticized for too much talk and too little action. Relevant to this feeling is Thomas Mann's statement, "Speech is civilization itself. The word, even the most contradictory work, preserves contact -- it is silence which isolates".

REACTIONS FROM SPEAKERS AND STAFF

The speakers and staff for the conference who remained for the three-day Institute had an opportunity to observe and gain general impressions of the productive thinking from the participants. As a result there is hearty endorsement of the written reports from these groups. The comments from those of us who were close to the scene but not actual participants are, therefore, submitted to provide some emphasis and perhaps a few supplementary suggestions.

The one important message which we have heard coming through loud and clear is that we do indeed have a great deal to say to each other. Strategies for teaching children have wide applicability regardless of the labels they may wear.

As we function with children with multiple handicaps, we need to be aware that many of our ivory towers are indeed crumbling -- many of our idols do indeed have feet of clay.

As we have talked, the speakers to you and you back to the speakers, some significant new thoughts seem to be emerging:

1. Perhaps we need to think of all handicapped children as children with multiple handicaps. We

talk about mentally retarded children as if mental retardation exists in isolation. And yet most of us have never been in a mentally retarded class that did not have some physically handicapped children in it -- that did not have some emotionally disturbed children in it -- or some culturally disadvantaged children -- or some children with perceptual problems in it. We have never been in a class for the blind that did not have some brain injured children in it, some emotionally disturbed children, or some socially maladjusted children.

2. This may be the time for us all to call into question the precepts which were imparted so confidently by our professors in graduate school, and to realize that populations of handicapped children change as science makes continuous inroads into prevention and treatment. Today's young blind children may be quite different from yesterday's retrolental fibroplasias, and may need a very different kind of educational programming than we were committed to ten years ago.

3. It is apparent that we have heard a plea to all of us to hang loose -- not wishy-washy, but flexible enough to learn from each other and from the children so that we are constantly evaluating and adapting

new methods with old ones!

4. Have we not been saying that we need to listen to and adopt any technique from any field that may have some promise for the children we are called upon to teach? We appreciate Dr. McCarthy's attempt to devise a checklist of possible modes of intervention in children's behavior which have come up in the conference, and which seem to have some relevance to the problems of educating children with multiple handicaps.

It is important that we all be conversant and knowledgeable about each of these modes of intervening in children's behavior. For some children, and some kinds of behavior, we may need to use one technique; for other children, and other kinds of behavior, we may need to use them all!

Models of Intervention in Children's Learning Processes

I. The Operant-Conditioning Model

A. Behavior modification through the control of antecedent environmental events and subsequent events (using token reinforcement, social reinforcers, or food reinforcers).

What? ☐ Cognitive ☐ Social ☐ Academic

Where? ☐ Group ☐ Individual School Social
Who? ☐ Teacher ☐ Psychologist ☐ Worker

II. The psychoanalytic Model

- A. Concentrates on emotional changes within the child and in the parent-child interaction.

III. The Social-Interaction Model

- A. Involves changes in the environment, not just in the child.
- 1. Classroom changes
 - 2. Teacher changes
 - 3. Method changes
 - 4. Parent changes

IV. The Psycholinguistic Model

- A. Involves language development and the direct training of the psychological processes which underlie learning.
- B. The task analysis model, which is the other half of the psycholinguistic model, involves a careful description of the demands of the task so that we can match the demands of the task to the cognitive style of the learner.

We also endorse Dr. Peter's insight into and respect for the social and psychological approach to understanding human behavior, and his plea for our consideration of pre-

scriptive teaching with all that it implies in our direct service, evaluation, and administration of programs. Not only his theoretical approach, but his actual working relationship with children provided encouragement for teachers who desire to become more open to these children, regardless of the severity of their problems.

Dr. Lehrmann represented for us not only models for administration, but a strong leaning toward modification of human behavior, utilizing certain of the well-known models.

As we observed examples of demonstration projects planned specifically for children with multiple handicaps, considered the psychiatric approach with certain children, and the important ingredients of functional parent-child and parent-school cooperative study and service, we were able to see our opportunities and obligations.

Sometimes it seems that, just when we get a particular service for children to the point where it is functioning well, the service in terms of children's needs is outdated. We all too often are reluctant to discard a program for which we have expended much time and energy in bringing it to fruition. Certain ideas will die hard, and programs personnel may be very resistant to change, but die or change they must in the face of the current needs of severely handicapped children.

Administrators have often been met with silence when

they make a statement such as "All right, my district and I admit an obligation and responsibility to multi-handicapped children. But whom do I employ to teach such a class? And what will be the structure and curriculum for this class"? Many suggestions or answers to these questions have been made or implied during this Institute. With no authoritative guidelines available, why not try one of Dr. McCarthy's models? Prescription teaching or an "engineered classroom" might be worth a try.

The mistake -- the tragedy -- is to refuse to try. To postpone action by waiting until someone proves through research that a particular technique is effective with multi-handicapped children, is to neglect these children.

The relationship between the area of education of visually impaired children with multiple handicaps and the presentations during this Institute is obvious. To label this an Institute on the education of visually impaired children, or mentally retarded children, or children with learning disabilities, is to miss the major theme of the three days. No matter what our role is, no matter what our specialization is, we have much to learn from each other.

Those among us whose major area of interest is that rather nebulous category called "Learning Disabilities" may have been less interested in materials and the mechanical

adaptation of curriculum than have other areas of special education. Emphasis in the area of Learning Disabilities has concentrated in developing strategies for teaching based on children's behavior, and techniques for modifying behavior. Perhaps we all need to rely less on the "hardware" in teaching multi-handicapped children, and give more attention to the human needs of children. Where there is need for this "hardware", our understanding of children will prompt our wise selection and use of it.

To label ourselves heretics, to say that our idols are tumbling, is to admit that what we are now offering in educational services for multi-handicapped children is not working. Now we teachers, administrators, psychologists, social workers, etc., must have the courage, the creativity, and the ingenuity to try to combine our efforts in arriving at new ideas and techniques.

We have suggested, at this Institute, that all of us have a responsibility -- the State Department of Education, the teacher preparation programs, the community services, and the schools. Every one of us should leave this Institute with a deep commitment to our own individual responsibility for bringing the best, most appropriate service to each multi-handicapped child.

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